HHA PPS MAILBOX QUESTIONS

VOLUME II, February – Batch 1

The questions below, which in some cases have been paraphrased, were sent to: *HHPPSQuestions@HCFA.gov* during the period referenced above, on the Home Health Prospective Payment System (HH PPS). It is our intention to continue to answer question that come into that mailbox in monthly batches, and post those answers at: *www.hcfa.gov/medlearn/refhha.htm.* In cases where time was needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

List of Home Health Prospective Payment System (HH PPS) Billing Questions, Volume II, Batch 1:

HH PPS Billing Questions Cross-reference, Volume II, Batch 1:

Discharge: 5, 6
Transfer: 3, 4, 5
[Final] Claim [Bill]: 3, 4, 5, 6, 7
HHRG: 1
Overlapping Episodes: 3, 4
Timely Filing: 3
Source of Admission Code: 3
HIHQ: 4
MSP: 4, 7
Claim Through Date: 6
Demand Bills: 7
No-payment Bills: 7
HH PPS Transition Period: 8
HH PPS Pricer: 1

General Terms/Acronyms

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

HH = home health
HHA = home health agency
HCFA = Health Care Financing Administration, previous name of the Federal Agency administering Medicare. Note: The name of the agency was changed in June 2001 to the Centers for Medicare and Medicaid Services (CMS).
HHRG = Home Health Resource Group, the payment group for HH PPS episodes
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44
MSA = Metropolitan Statistical Area, a series of codes representing geographic locations put on Medicare HH claims so that payment is commensurate with the location in which services are delivered.
MSP = Medicare Secondary Payment. Cases where Medicare is the secondary, rather than primary, payer on a claim.
OASIS = Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home care.
Outlier = An addition to full episode payment when costs of delivering services exceed a fixed loss threshold.
RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.
RHHI = Regional Home Health Intermediary. Medicare fiscal intermediary specializing in the processing of hospice and home health claims..
PPS = Prospective Payment System. The method under which Medicare pays for home care under a plan of care from October 1, 2000 on.
SNF = Skilled Nursing Facility

VOLUME II, Batch 1, HH PPS Billing QUESTIONS and ANSWERS

Policy - HIPPS (HHRG) Payment Calculation

Q1. How or where can we obtain the HHRG payment rates for our area?

A1. HHRGs are represented by HIPPS codes on HH PPS claims. Each HHRG is represented by eight HIPPS, which vary based on how a payment group was formed from a particular OASIS assessment (i.e., a "1" at the end of the HIPPS means all needed OASIS elements were completed, none were derived). A table of HIPPS codes and weights can be found at our website at www.hcfa.gov/medlearn/refhha.htm. Note that toward the bottom of this page, there is a header for the "Home Health Payment System Training Session", and the tables are listed under this header.

The weight for the applicable HIPPS code is multiplied by the national standard episode amount of $2,115.30 for FY 2001 (October 1, 2000 to March 31, 2001) and $2,161.84 for FY 2001 (April 1, 2001 to Septemeber 30, 2001). This product of this multiplication is then split according to ratios for the labor and non-labor portion of the payment. The total product should be multiplied by.77668 to produce the labor portion, and that same total by .22332 to produce the non-labor portion of the episode.

The labor portion alone is further multiplied by the MSA wage index for the area in which the service is delivered—for home care, the beneficiary's home. A table of MSAs can be found in the HH PPS Final Rule, Section IV. B. 4., Hospital Wage Index; however, corrections to this list must also be consulted. Note also that on claims for rural areas, represented by MSA codes beginning with "99", the national standard episode amount is increased in Medicare claims systems by 10 percent as of April 1, 2001, as required by law. Both the correction list and the Final Rule providing MSAs can be found at the website address or URL given above.

The product of the labor portion multiplied by the MSA wage index is then added back to the non-labor portion to produce the total possible episode payment for a given HIPPS in a given MSA. It should be noted, however, that payment can change further if payment adjustments like PEPs or outliers apply to specific episodes.

Since there are hundreds of HIPPS and thousands of MSAs, most billing vendors have built this calculation into software for their clients. We also have not posted this information on our website given the size of such tables if every value were to be calculated out, nor do we expect all these calculations to be found on the websites of our RHHIs.

Many of these calculations occur in HH PPS Pricer software. This software can be downloaded from the HCFA website at the following URL:

www.hcfa.gov./medicare/nm75ght/priceint.htm

Q2. Provider support at my RHHI told me that somewhere on their own or your website, a person could enter a HIPPS code, and a MSA to see the payment calculation would be produced. Where is this located? I cannot seem to locate it on either website.

A2. We contacted your RHHI, and they responded this information is not found on their website. See Answer 1 above for how to calculate this yourself using HCFA web resources.

Billing Requirements

Q3. If a RAP is billed out of order, will it be rejected? Here is my example: the start of care is 10/01/00. The subsequent RAP of 11/30/00 is billed first, and then the 10/01/00 RAP is submitted later. Will the 10/01/00 RAP get rejected? I understand that a subsequent RAP may be billed before the final claim, but does the RAP need to be submitted sequentially?

A3. The answer to your question depends on whether or not another episode has been billed for the same beneficiary in the 60 days of the episode that would be created by your "late" RAP. Assuming you have been the only HHA providing services to this beneficiary, and that this prior episode does not overlap with the later one you already established in your example, the answer to your question is no, your RAP would not be rejected because it was submitted out-of-order.

Ideally, Medicare systems will allow episodes to be established anytime within the timely filing period for filing Medicare claims. This period is 15-27 months after services were delivered, depending on the month services were provided. You may bill anytime in the next calendar year after services were provided, and for services provided in the last quarter of the calendar year (September through December), this period extends through the two next calendar years.

Since HH PPS went live, we have found that in many cases out-of-sequence episodes cannot be established if they overlap with existing episodes, which was not our intent. We are working on changing our claims processing systems, but do not anticipate a fix to be in place before Calendar Year 2002. However, establishing transfer episodes can still be done with the use of the appropriate source of admission codes on the claim-- "B" or "C"-- assuming the transfer episode period only overlaps with an episode prior in time. It is also important to note that overlap between agencies does not include the date of transfer—both agencies, the transfer from agency and the transfer to-- can bill for this day.

In the interim, the best thing HHAs can do is to bill as timely as possible, and in sequence as much as possible, even though this is not a Medicare requirement. RHHIs will be working to intervene manually, and process as many of the out-of-sequence episodes as possible, but such processing will be protracted.

Q4. I tried to bill a PEP, but was unsuccessful. Apparently I have to adjust the previous bill, and then submit the RAP. I have gotten different answers from each person I have asked. Can you tell me how to fix this problem?

Also, I've had several RAPS "held" until the final claim is submitted. The RAP is "approved for payment", but with a "Z" after the code. Why is this happening?

And finally, do we have any idea when error code "38107" will be fixed? I have a lot of claims waiting for this to be fixed.

A4. Regarding the first part of your question, all that has to be done to have an episode payment "PEP'ed" is to use patient status code 06 on the HH PPS claim. When this code is used, the payment on the claim will be pro-rated such that payment will be made from the first date of service in of the episode until the last date of service of the episode. The most common reason to bill a PEP episode is if a HHA knows a patient has transferred from their care to another HHA in the same 60-day period, and has received services from this other agency in the 60 days.

We suspect what is happening is that you cannot bill a RAP or claim because an episode you previously billed is overlapping with the period you are trying to bill for now (see Answer 3 above), therefore requiring the previously billed episode to be adjusted. You can use the on-line inquiry screen HIQH, available through your standard system claims processing software (FISS, APASS), to see when other episodes for the same beneficiary have been created.

Regarding the second part of your question, we do not believe your RAPs, or the payment for the RAPs, is actually being held. The "Z" you refer to is an internal processing no payment code, which is placed on RAPs when Medicare is the secondary, rather than the primary, payer. Medicare will not pay RAPs when it is the secondary payer, though it will process RAPs to completion. In these cases, Medicare will pay the full amount due for the episode, usually the full episode payment, <u>less</u> payments made by the primary payer, in response to receiving a claim for the episode. Instructions on Medicare Secondary Payment and RAPs can be found in Sections 3682.4 and 3682.5 of the Medicare Intermediary Manual.

Regarding the final part of your question, error message 38107 in the FISS standard system is a valid error message alerting you that a RAP cannot be found for an episode for which a claim is now being submitted. Our guess is you are receiving this message because of the RAP auto-cancel function. This means a RAP will be canceled and its funds recouped if it is not followed by a claim for the same episode in 120 days from the start of the episode, or later if the RAP is suspended in

processing. There were problems with the RAP auto-cancel function at first, but those were fixed about the same time you submitted this question. If you are still having problems with this error message, you should consult your RHHI.

Q5. If a patient has been discharged due to a move out of a service area represented by a single MSA, and we do not know if they will be admitted to another agency, outpatient or other, what code should be used for a discharge reason?

A5. You may use any established patient status code you believe is appropriate including 01, "discharge to home/self care", in Form Locator 22 of the UB92 claim. You should <u>not</u> use the code 06 to represent a transfer, <u>unless</u> you are absolutely sure the patient is going to another home health agency, as use of this code will result in receiving a pro-rated or reduced episode payment--a PEP adjustment (see Answer 4 above). If the 06 if not used, you will receive the fullest episode payment allowed for the entire 60 days based on the number of services you alone provided, <u>unless</u> the patient receives home care somewhere else in the same 60-day period. If the patient does receive such care, your payment will be automatically pro-rated by Medicare, so your billing does not need to reflect this possibility.

If you believe there is a possibility your patient will need other care after discharge from your agency, it would be in your patient's best interest to bill as soon as possible after discharge, though you are allowed to bill anytime in the timely filing period (see Answer 3 above). Timely billing may help prevent any payment problems for providers who subsequently treat this patient caused by home health consolidated billing, though we are also mid-process in changing Medicare computer systems to enforce consolidated billing less strictly, though still adhering to this policy as required by law.

Q6. Our RHHI told us today that the "through date" on the UB92 must be the same as the "last visit date." But we have a newsletter from December 5, 2000, which states these dates do not need to coincide, and enforcing edits in the Medicare claims processing systems were to be removed effective Wednesday, November 29, 2000. Were the edits removed? We ask because we have a patient who was discharged to SNF two days after the last visit.

A6. We believe you were given old information based on previous, more rigid instructions. There were edits that enforced the earlier instruction, but all this programming has been removed.

The through date on your claim for an HH PPS episode is flexible, and can be the date you discharge the patient, which may or may not be the last billable service in that episode. If you are not discharging the patient, who will continue to receive services into another episode, the through date should be the 59th day after and not including the day the episode begun.

Current instructions for completing the through date on a HH PPS claim are found at Section 3638.24 of Medicare Intermediary Manual. Updates to this text were also released the end of June.

Dual Eligibles

Q7. I am new to this so please bear with me. If we know in advance that a patient is going to be denied Medicare payment, i.e., has homemaking paid by Medicaid, may we go ahead and bill the secondary insurance while we are waiting for Medicare's decision?

A7. Usually, any insurer or payer requires you first bill any other payers that may have more responsibility for payment-- and receive the other payer's payment or decisions regarding payment-- before you bill them. If the patient in question is a dually-eligible Medicare and Medicaid patient, Medicaid requires you first bill Medicare, and will only pay some or part of the total balance owed, less whatever Medicare paid. In general, Medicaid is known as the payer of last resort, and you should attempt to bill all other possibly applicable insurance before you bill Medicaid.

If you, the HHA, the physician authorizing the plan of care, and the patient are all in agreement that no Medicare covered services are being delivered, even if the patient has Medicare coverage, you do not need to bill Medicare with either a "regular" claim, or a demand bill. A demand bill asks for a formal decision whether or not Medicare will cover specific services. In these cases you may instead submit what is often called a no-pay or non-payment bill, or billing for receipt of a denial notice, which will be processed by Medicare and provide documentation of a Medicare payment decision. This option could be appropriate for something like homemaker services that are never covered by Medicare.

However, in the past, some Medicaid programs have nonetheless required Medicare be demand billed, rather than be sent no-payment bills, so check with your State program. Also see the Medicare Intermediary Manual, Sections 3638.30 and 3638.31, for instructions on billing both demand and no-payment bills under HH PPS, or contact your RHHI for further guidance.

OASIS:

Q8. I was just wondering what I need to do since I have several OASIS assessments that, when transmitted, are coming up with the warning about out of the five-day window. These OASIS assessments are for continuing care clients receiving our services for a considerable time before October 1, 2000, the start of HH PPS, and therefore the five-day windows differ. These cases were never corrected to reflect specific 60-day periods during the period allowed in October 2000. I was wondering if these OASIS should be corrected ASAP, or left and just transmitted as is, disregarding the error message. I am especially concerned because I thought those warnings were looked at when we are audited. What can be done?

A8. The grace period designed to ease the burden of transition to the new payment system allowed OASIS assessments done from September 1, 2000 forward to be applied to a period of up to 90 days, ending no later November 29, 2000. This was a one-time exception to the 60-day certification period.

Patient assessments that were on a two-month follow-up assessment cycle according to the comprehensive assessment requirements in effect prior to implementation of the prospective payment system will continue to experience these warnings. If the patient has been on service for a considerable time, the calculated due date for follow-up assessments according to a 60-day re-certification schedule may differ substantially from the two-month re-certification schedule in place prior to PPS.

Since all patients subject to OASIS on service at the inception of PPS were not expected to alter the true start of care date, and the software calculates the follow-up based on the start of care date, there will be warnings. These warnings are associated with going from the previous version of the data entry software (with a 2-calendar month follow-up timeframe) to the current version of the data entry software (with a 60-day follow-up timeframe). The warnings result from the fact that the software will calculate due dates for follow-up assessments according to the new, 60-day follow-up schedule, when the start of care date is before October 1, 2000.

In this situation, the warnings can be ignored with no consequence to the home health agency. We have alerted the survey field to this situation.